

Third Quarter 2002 Summary of Incidents, Complaints, and Enforcement Actions

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**“Any complaints and or incidents involving hospitals on or after August 30, 1999 are not
releasable under the Texas Public Information Act & The Health and Safety Code
Chapter 241.051 (d). The text of these summaries will not appear in this report.”**

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SUMMARY OF INCIDENTS FOR THIRD QUARTER 2002

I-7914 - Radioactive Material Found - Federal Bureau of Investigation (FBI) - Dallas, Texas

On July 3, 2002, the FBI requested assistance from the Agency to conduct radiation surveys during the search of a Dallas residence. The FBI believed a beta emitting radioactive material was located in the residence. The Agency responded to investigate and provide radiological assistance. A basket located in the living room gave radiation readings of 20,000 counts per minute near the surface. The basket contained a small plastic box, a 9 volt battery and a small metallic tin packaged in porcelain bowls. A gray pasty substance within the tin was the origin of the radioactivity. A sleeping mat in an upstairs bedroom gave radiation readings of 10,000 counts per minute. The items were secured, packaged, and taken into possession for disposal by the Agency. A survey of other areas of the residence indicated background levels of radioactivity. First responders involved in the incident were surveyed and none were contaminated. U.S. Customs contacted the person to whom the package was being sent. The individual indicated the item was a religious object that did not need to be returned.

File Closed.

I-7915 - Damaged Moisture/Density Gauge - Golder Associates, Inc. - Houston, Texas

On April 12, 2002, the Licensee notified the Agency that a moisture/density gauge, containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, was damaged on March 14, 2002. The operator of the gauge had just completed density testing on soil. He moved to see the thickness of soil being moved by a bulldozer working next to his equipment. The bulldozer reversed direction and backed over and damaged the unattended gauge. The gauge operator evacuated construction personnel within 100 feet of the gauge and then notified the radiation safety officer of the incident. The radiation safety officer surveyed the gauge then placed it in its transport container for transport to the local company for disposal. A leak test by the gauge manufacturer determined that neither source was leaking. To prevent a recurrence, the gauge operator was sent to refresher training on proper care, maintenance, and operation of moisture/density gauges and was given a work suspension without pay. The Licensee was cited for failure to maintain surveillance of radioactive material in an unrestricted area.

File Closed.

I-7916 - Eye Exposure - University of Texas Medical Branch - Galveston, Texas

On July 19, 2002, the Registrant notified the Agency of a laser injury that occurred during an operation on June 14, 2002. Medical confirmation indicated a researcher received sufficient energy to cause an injury. The researcher was aligning a laser system in preparation for an experiment. The laser system was capable of producing infrared, visible, and ultraviolet laser radiation at 1064, 532, and 355 nanometers. The experiment called for the use of the visible 532 nanometer wavelength laser beam. The laser system did not have an alignment laser, therefore, the researcher reduced the energy of the laser by reducing the laser output and inserting neutral density attenuation filters into the beam path. The operator believed that a filter required to block the 1064 nanometer beam was also present in the laser beam-path, but it was not. The absence of the filter from the optical train allowed the invisible, 1064 nanometer, laser beam to accompany the visible, 532 nanometer, laser beam. For this experiment, the optical train terminated at an optical transducer with a reflective metallic surface. It is believed that the injury resulted from exposure to the 1064 nanometer laser beam reflecting from the transducer surface on the researcher. The researcher was not wearing protective wear at the time of the accident, although she had been trained to wear them. An Agency investigation confirmed the damage. The researcher is no longer affiliated with the Registrant; she returned to Russia for further medical treatment. To prevent a recurrence, the Registrant developed and presented enhanced training for employees, reviewed the safety aspects of all laser research protocols, performed random inspections to ensure safety compliance, and increased the severity of disciplinary actions to include possible dismissal for noncompliance. The laser was evaluated to explore possible modifications of the safety features. Filter warning labels were placed on the laser unit and procedures were changed to require the use of an energy meter to detect and verify the expected dose of light.

File Closed.

I-7917 - Badge Overexposure - Non-Destructive Inspection Corporation - Lake Jackson, Texas

On July 16, 2002, the Licensee notified the Agency of a 28,214 millirem overexposure to an industrial radiographer during the monitoring period May 20, 2002 through June 19, 2002. An Agency investigation could not determine the cause of the overexposure. The radiographer stated that his badge may have been intentionally overexposed when left in a company vehicle. The inspector could not substantiate this allegation. Pocket dosimetry records for the radiographer during the monitoring period indicated normal levels for industrial radiography operations. It was also discovered that the radiographer's badge for the previous monitoring period, April 20, 2002 through May 19, 2002, was missing. Assessed doses of 417 millirem and 292 millirem, based on pocket dosimetry records, were requested by the Licensee and accepted by the Agency for the two monitoring periods. A

violation was cited for missing survey records for the date May 28, 2002.

File Closed.

I-7918 - X-Ray Units Lost - Motorola, Austin, Texas

On July 18, 2002, the Registrant notified the Agency that two x-ray units could not be located on July 17, 2002. The units were identified on inventory as having been transferred offsite. However, all attempts to locate transfer records were unsuccessful. Area representatives involved in the decommissioning and closure of factory and support areas verified the machines had not been lost or stolen but were transferred offsite. The Registrant believes the units were transferred to another facility, donated to a university, sent back to the tool manufacturer, or decommissioned in accordance with company policy. The Registrant was cited for failure to maintain control of radiation producing machines.

File Closed.

I-7919 - Badge Overexposure - All American Inspections, Inc. - San Antonio, Texas

On August 1, 2002, the Licensee notified the Agency of a 6,640 millirem overexposure to an industrial radiographer for the April 10 through May 9, 2002, monitoring period. The radiographer was performing radiography in a shooting bay when he dropped his film badge, pocket dosimeter, and alarming rate meter. He performed three exposures for three minutes each with a 24 curie iridium-192 source before he discovered his badge lying on the floor two to three feet from the source. The incident was reported to the radiation safety officer. The pocket dosimeter reading was off-scale. The Agency granted a deletion and accepted a 5 millirem assessment, based on exposure history, to be added to the radiographer's exposure record. The Licensee was cited for failure to submit the badge for immediate processing upon discovering the pocket dosimeter had discharged beyond its upper range.

File Closed.

I-7920 - * Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7921 - Source Abandoned Downhole - Schlumberger Technology Corporation - Sugar

Land, Texas

On July 31, 2002, the Licensee notified the Agency of the decision to abandon downhole two sources after unsuccessful recovery attempts. The 16 curie americium-241/beryllium source, and 1.7 curie cesium-137 source were abandoned on August 3, 2002, at depths of 10,464 feet, and 10,478 feet respectively. A red dyed cement plug of 1,110 feet with anti-intrusion device was set in the well casing. The sources were abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253. A plaque was ordered for attachment to the wellhead.

File Closed.

I-7922 - Shipment Irregularity - Southwest Research Institute - San Antonio, Texas

On August 9, 2002, a Texas Licensee notified the Agency of a shipment irregularity that occurred on August 9, 2002. A package contained a 980 curie cobalt-60 therapy source with Yellow II labels indicating a transport index (TI) of 0.8. An agency investigation determined the package had a TI of about 2. The source was being shipped from Mexico to a cancer center in Pittsburg, Kansas. The shipment was held at the border in Laredo, Texas and routed to an authorized Texas Licensee's facility for investigation because radiation levels on the exterior were higher than indicated on the shipping label. Some confusion also resulted because a freight forwarder indicated the package was empty. An Agency investigation determined the contents had shifted during transport. The Texas Licensee opened the package, adjusted the contents appropriately, and returned the shipment to Mexico.

File Closed.

I-7923 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7924 - Dose Irregularity - Don & Cybill Harrington Cancer Center - Amarillo, Texas

On September 6, 2002, the Registrant notified the Agency of a dose irregularity that occurred on September 6, 2002. A patient was treated on a teletherapy unit using a treatment plan intended for another patient. The patient and referring physician were notified of the error. The physicist's calculation of the effect to the treatment volume was less than 1% of the total dose. The dosimetrist determined that a change to the patient's treatment plan would not be necessary. To prevent a recurrence, the Registrant: improved the patient identification process, improved the monitoring process for staff compliance with procedures, counseled the therapist, implemented a patient bar-code appointment slip, held an in-service with staff to review improvements, and recruited additional staff to lighten the therapist's workload.

File Closed.

I-7925 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7926 - Radioactive Labeled Pipe - Arboretum - Austin, Texas

On September 9, 2002, the Austin Police Department (APD) notified the Agency that abandoned pipes labeled with radioactive warnings were found on September 9, 2002. A pedestrian out for a walk found three liquid-filled plastic pipes marked "caution radiation" in a shopping center parking lot near a construction site. The Austin Fire Department (AFD) and APD responded. The Agency (BRC) was contacted through our 24-hour emergency system and responded to the scene. The BRC, AFD, and APD worked together to investigate any potential hazard. Although radiation surveys of the pipes at the scene did not indicate elevated readings, as a precaution, BRC took possession of the pipes until further investigation/analyses could take place. Due to the heightened alert of the upcoming 9-11 anniversary, it was decided APD would perform tests to rule out the possibility of a terrorist act. Also, the response actions presented a training opportunity. The APD Bomb Squad examined the contents of the tubes and found nothing noteworthy. The Bomb Squad then transported the suspicious tubes to the AFD training grounds for further testing. The tubes were opened remotely and the liquid inside tested by robots. The analyses indicated the tubes contained only water. The contents and tubes were released to the AFD for disposal.

File Closed.

I-7927 - Badge Overexposure - Valley View Surgicare - Dallas, Texas

On September 6, 2002, the Registrant notified the Agency of a 5633 millirem exposure to a physician that occurred during the January 15 through April 14, 2000 monitoring period. The exposure was discovered during a records review in preparation for an Agency compliance inspection. The badge was not turned in a timely manner and had been continuously left in a room with an x-ray unit. The exposure was recalculated by the badge processing company resulting in a final dose of 1689 millirem deep dose equivalent for the monitoring period. To prevent a recurrence, the Registrant replaced the Radiation Safety Officer who did not turn in monitoring devices in a timely manner, and has monitored the physician's use of the monitoring device. The recalculated dose was added to the physician's exposure history.

File Closed.

I-7928 - Radioactive Material Found - SMI - Seguin, Texas

On September 9, 2002, the Licensee notified the Agency that radioactive material was found in a load of scrap metal on August 29, 2002. A man-made device was removed from the scrap. An analysis by a consulting Licensee determined the radioactivity was from radium-226 paint. The label on the device indicated an inspection date of March, 1958. An owner could not be identified. The consultant for the Licensee took possession of the device for disposal.

File Closed.

I-7929 - Mis-shipment - The University of Texas at Austin / Perkin-Elmer Life Sciences, Inc. - Austin, Texas / Boston, Massachusetts

On August 2, 2002, the Licensee notified the Agency of a shipment of radioactive material that had been shipped on August 1, 2002, to the wrong University of Texas location. The shipment consisted of two vials of phosphorus-23, each with an activity of 0.25 millicuries, that should have been shipped to the University of Texas, M.D. Anderson Cancer Center, Houston, Texas. The shipment had been mislabeled with a duplicate of a label from a second package that had been requested by an authorized user at The University of Texas at Austin. At that time it was determined that the material was in the wrong chemical form to be used by the authorized user and was retained by The University of Texas at Austin for decay in storage. The shipper was investigating the cause of the mislabeled shipment. No violations were cited.

File Closed.

I-7930 - Badge Overexposure - Acute & Chronic Pain - Amarillo, Texas

On August 26, 2002, the Registrant notified the Agency of a 4,525 millirem exposure to a physician during the July 10, 2002 through August 9, 2002 monitoring period. An Agency investigation determined the exposure was only to the badge. The physician had been experimenting with wearing the badge attached at different body locations outside of a lead apron. The badge monitored a higher dose when worn below the knees during fluoroscopic procedures. To prevent a recurrence, the physician was advised to wear the badge near the collar. As a precaution to reduce exposure, the physician is planning to utilize additional shielding around the fluoroscopy unit (table). A deletion was allowed and a 364 millirem assessment was accepted, based on past average exposures. The investigation determined the facility had been in operation since 1999 and was unregistered. A violation was cited for failure to register.

File Closed.

I-7931 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7932 -* Health and Safety Code-Chapter 241.051(d)

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SUMMARY OF COMPLAINTS FOR THIRD QUARTER 2002

C-1687 - Uncredentialed Technologist - Express Mobile X-Ray, Inc. - Friendswood, Texas

On July 8, 2002, the Agency received an anonymous complaint alleging the Registrant allowed an uncredentialed technologist to perform radiographs. An Agency investigation performed on August 1, 2002, determined that the facility employed only fully credentialed technologists. The name of the alleged uncredentialed technologist was unknown to the Registrant and other technologists employed at the facility. The complaint could not be substantiated. After a complete inspection, no violations were issued.

File Closed.

C-1688 - Unregistered X-Ray Facility - Dr. Luis Magnucci - Plano, Texas

On July 24, 2002, the Agency received a complaint alleging an unregistered facility was operating an x-ray unit. An Agency investigation determined the facility was registered. The complaint was invalid.

File Closed.

C-1689 - Unregistered Service Company - C&R Medical Consultants - Rowlett/Mesquite, Texas

On July 30, 2002, the Agency received an anonymous complaint alleging that an x-ray tube head was leaking tube oil at a residence in Rowlett, Texas. It was also indicated that the equipment belonged to a firm called C&R Medical Consultants which was allegedly operating as an un-registered service company. An Agency inspection was performed on September 9, 2002, which determined that the tube head was leaking tube oil on the driveway. The date of manufacture indicated that the tube head contained only mineral oil that was not contaminated with PCBs. Contact with the owner of C&R Medical Consultants indicated that the firm is not a service company but performs as a middleman linking potential customers with registered service companies in the area. The owner was notified of the leaking tube head and proceeded to clean the spilled mineral oil. The complaint could not be substantiated. No violations were cited.

File Closed.

C-1690 - Regulation Violations - Classic Imaging - Royse City, Texas

On July 29, 2002, the Agency received a complaint alleging a Registrant failed to supply personnel monitoring to individuals performing radiation work. An Agency investigation substantiated the allegation. The Registrant was cited for: failure to monitor the occupational exposure to radiation of an employee; failure to keep a daily log of all services and installations performed; and failure of the radiation safety officer to establish and oversee operating and safety procedures and maintain records of the personnel monitoring results.

File Closed.

C-1691 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1692 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1693 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1694 - Regulation Violations - Steeplechase Diagnostic Clinic - Houston, Texas

On August 12, 2002, the Agency received a complaint alleging a facility lost a patient's mammogram films. An Agency investigation was unable to determine who was last in possession of the missing mammogram films or where the films are presently located. An Agency investigation confirmed the films for the mammogram examinations, performed prior to August 2001, could not be located at or by Steeplechase. The facility maintains that the films are unavailable because they were released to the patient and not returned to the facility. Although the facility claims the films were not returned, as a courtesy, they have performed an extensive search for them. In an effort to locate the films, the facility contacted the patient's physician and all mammography facilities in the Houston area to

request a search for the films. None of the facilities were able to locate the films in their medical files. The means used by the facility to check in mammogram films, as they are returned, was reviewed during the Agency's investigation. In May 2002, a new administrator at the facility added the use of a logbook to document the release and return of films. Prior to May 2002, the release of films was tracked by placing a release form in the film file jacket and recording the loan on the front of the jacket. The investigation did not identify any items of noncompliance with Agency regulations.

File Closed.

C-1695 - Regulation Violation - Technical Welding Laboratories, Inc. - Pasadena, Texas

On August 13, 2002, the Agency received a complaint alleging that: the Licensee was maintaining an insecure storage facility for radioactive material; the shielding at the facility is in poor condition allowing potential exposure to radiation workers; the overhead canopy at the facility potentially allows the radioactive material to be exposed to rainwater; the rainwater drains into a public drainage ditch potentially damaging the environment; the proximity of the facility to a public street is a potential exposure hazard; and the condition of the shielding subjects the radioactive material stored on site to potential theft. An Agency investigation determined that: the facility addressed in the complaint is a temporary job site for industrial radiography; the shielding at the facility was sufficient for the operations performed at this site; no radioactive material is stored at this site; there is no basis for suspected contamination of the site or possible theft of the radioactive material. The allegations could not be substantiated. No violations were issued.

File Closed.

C-1696 - Regulation Violations - Genus Inc./Varian - Austin, Texas/Sunnyvale, California

On August 20, 2002, the Agency received a complaint alleging personnel monitoring records for the 1996 through 1998 monitoring period were not supplied to a former employee upon request. An Agency investigation determined the company had only had the request for four days and were searching for the requested records. The company determined the former employee was not an occupationally exposed worker and was not monitored for radiation exposure.

File Closed.

C-1697 - Unauthorized Disposal of Radioactive Material - Chambers County Waste and Disposal - Monroe City, Texas

On August 15, 2002, the Agency received an anonymous complaint forwarded by the Texas Commission on Environmental Quality (TCEQ). The complaint alleged that the facility was illegally disposing of radioactive medical waste in an incinerator. A TCEQ investigation determined that there had been no radioactive material at the site. This Agency concurred with the result of that investigation. No violations were issued.

File Closed.

C-1698 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1699 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1700 - Uncredentialed Technologists - Kirkwood Medical Center/Industrial & Urgent Care - Pasadena, Texas

On September 3, 2002, the Agency received a complaint alleging a facility was unregistered and allowed uncredentialed technologists to perform radiographs. An Agency investigation substantiated the allegations. The facility was cited for the violations. The company was also cited for failure to conduct equipment performance evaluations for an x-ray unit and for failure to monitor the occupational exposure to radiation of the technologists.

File Closed.

C-1701 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1702 - Unregistered Laser Sales & Service - Extreme Lasers - Seabrook, Texas

On September 9, 2002, the Agency received a complaint alleging a company was selling ClassIIIB laser diode modules and modified laser pointers that are not certified. An Agency investigation determined the lasers were not energized by the seller and the business did not require a registration with the Agency. A registration application packet was provided to the company for future use if necessary.

File Closed.

C-1703 - Unauthorized Disposal - Port Iron and Supply Company, Inc. - Port Arthur, Texas

On September 13, 2002, the Agency received a complaint from a community action group alleging an unlicensed facility was receiving, storing, and disposing of scrap metal contaminated with radioactive material. The complainant stated that employees of the company were concerned about exposure to elevated levels of radiation from the scrap. The complainant described a returned load of scrap that had been rejected by a local scrap dealer. The scrap load was marked for identification with orange paint and placed at the side of the facility. An Agency investigation determined that the facility does not deal in radioactive scrap. However, infrequently the facility does receive scrap that has been contaminated with Naturally Occurring Radioactive Material (NORM). The facility admitted to having a load of scrap heater tubes currently located at the side of the facility. The Agency found the load to consist of six to eight inch pipe cut into 4-foot lengths and painted with orange paint which had been rejected by a local scrap dealer. When surveyed by the Agency, the heater tubes had no radiation levels above background. The facility segregated the load for return to the originator due to rejection by the scrap dealer. The facility had two survey meters equipped with 1x1 sodium iodide probes for identifying any scrap with levels of 10 uR/hour prior to shipment to a scrap facility. All contaminated scrap detected at the facility is returned to the originating facility per company Standard Operating Procedure. No violations were cited.

File Closed.

C-1704 - Unauthorized Disposal - Diagnostic Imaging/Austin Regional Clinic - San Antonio/Austin, Texas

On September 13, 2002, the Agency received a complaint from a Registrant alleging a service company picked up an x-ray unit and was unable to account for its location. An Agency investigation determined the service company failed to notify the Agency within 30 days of the disposal or transfer of a radiation machine; records of receipt, transfer and disposal were not maintained at the authorized use location; and the RSO failed to investigate and report to the Agency the theft or loss of the machine. The service company was cited for the violations.

File Closed.

C-1705 - Uncredentialed Technologist - Kuykendahl Emergency Clinic - Spring, Texas

On August 5, 2002, the Agency received a complaint alleging an uncredentialed technologist was performing radiographs under the supervision of the radiation safety officer and facility medical officer. An Agency investigation determined that the alleged uncredentialed technologist was being trained by the physician to perform x-rays for a hardship exemption. The exemption had not been applied for, and the individual was only allowed to position patients and develop x-ray film. No violation was cited as the individual was not performing the duties of an x-ray technologist. The facility was referred to the Texas Department of Health's Medical Radiologic Technologist program for possible hardship exemption registration.

File Closed.

C-1706 - Uncredentialed Technologists - Doctors Clinic - Houston, Texas

On August 20, 2002, the Agency received a complaint alleging a Registrant allowed uncredentialed technologists to perform radiographs. An Agency investigation determined the physicians perform the x-ray procedures. No violations were cited.

File Closed.

C-1707 - Dose to Public - Solutia, Inc. -Alvin, Texas

On September 5, 2002, the Agency received a complaint alleging radiation exposure to a truck driver who transported a contaminated bulldozer on a tractor/trailer truck. The complainant alleged the bulldozer was used to push a reactor into a burial pit that contained waste catalyst sludge with less than 9% depleted uranium. The alleged radiation exposure was said to have negatively affected the truck driver's health. The truck driver transporting the bulldozer was allegedly treated for skin rash to his chest and arms, with an alleged diagnosis of possible radiodermatitis that was probably due to exposure to alpha radiation, possibly depleted uranium. An Agency investigation determined the bulldozer used during the incident was moved to the burial pit on mats, preventing contact with the contaminated soil and the reactor was pushed on a sled into the burial pit. The pit was regulated by the Texas Commission On Environmental Quality (TCEQ). After completion of the job, the trailer was draped with plastic, the bulldozer was loaded onto the trailer, and the bulldozer was wrapped in plastic and transported to a decontamination area. The trailer

and the bulldozer were both placed in the decontamination area and hydro-blasted to remove any potential contamination. The bulldozer and the trailer were both wipe tested and confirmed to meet the removable contamination levels prior to being released. The bulldozer remained at the decontamination site for approximately 2 weeks, during the cleaning and release process. The physician who was alleged to have made the diagnosis denied any knowledge of possible radiation exposure to any patient he had treated and could not find a record of treatment for the alleged patient. Exposures to the bulldozer operator and to the landfill personnel who were occupationally monitored for radiation exposure were all determined to be minimal during the period of this incident. Bioassays of the landfill personnel also indicated no levels of contamination of concern. The allegation could not be substantiated.

File Closed .

C-1708 - Unregistered Lasers - Extreme Lasers - Seabrook, Texas

SAME AS 1702.

File Closed.

C-1709 - Unauthorized Disposal - Streamline Production Systems, Inc. - Kountze, Texas

On September 23, 2002, the Agency received an anonymous complaint forwarded by the Texas Commission on Environmental Quality (TCEQ) which alleged the facility had disposed of a "load" of contaminated scrap that was rejected by a Beaumont, Texas scrap dealer after it was determined to have radiation levels above those acceptable to the scrap dealer. It was alleged that the scrap was returned to Streamline and was subsequently buried on the "back of the property". An Agency investigation determined that no on-site burial of contaminated scrap could be located on the approximately seven acre tract. Both the facility manager and the facility owner denied knowledge of the burial of any contaminated material. The investigator not could substantiate the allegation. No violations were issued.

File Closed.

C-1710 - Regulation Violations - Cathy Lyles - San Antonio, Texas

On September 23, 2002, the Agency received a complaint alleging a dental facility repeated a radiograph 15-20 times without producing a usable image. The complainant alleged the problem resulted from untrained staff and the dentist who was also uncertain of which technique to use. An Agency investigation determined a new digital x-ray unit was installed at the facility on September 19, 2002, and the first patient was radiographed on the day of the complaint. The initial setup to operate the digital unit is complex and the dentist and

staff were inexperienced at the onset, although training took place prior to use. The unit was operated with efficiency during the investigation. The Registrant was cited for failure to maintain records of current equipment inventory at the use location.

File Closed.

C-1711 - Mammography Film Retention - Center for Diagnostic Medical Services - Duncanville, Texas

On September 25, 2002, the Agency received a complaint alleging a Registrant that performed mammogram examinations on the complainant in 1997 and 1998, was out of business and could not be contacted. The complainant needed old films for comparison with new films. An Agency investigation determined the Registrant in question had sold its holdings, including films, to a second Registrant that performed mammography at the same location for approximately two years. When this mammography facility closed, its remaining assets were turned over to a holding company. The Agency took escalated enforcement action against the last mammography facility in January of 2000 resulting in an agreed order that the holding company would attempt to contact all persons having films at the facility and transfer films to them upon request. The agreed order specified that the films would be retained for a period of two years. On May 21, 2002, upon completion of the agreed period, the holding company was allowed to destroy all unclaimed documents and films. The complainant was informed that her films were destroyed under provisions of the agreed order. No violations were noted.

File Closed.

C-1712 - Regulation Violations - H&G Inspection Company Inc. - Houston, Texas

On September 26, 2002, the Agency received a complaint alleging radiographers holding Radiographer Cards issued by the State of Texas performed radiography operations in Alabama in an unsafe manner. An Agency investigation determined the employment of the two radiographers was terminated by the Texas Licensee and the radiation control program of Texas was notified. The incident was referred to the program issuing the cards and to the Alabama Department of Radiological Health for any actions deemed necessary.

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INCIDENTS CLOSED SINCE SECOND QUARTER 2002

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COMPLAINTS CLOSED SINCE SECOND QUARTER 2002

NO COMPLAINTS WERE CLOSED SINCE SECOND QUARTER 2002

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES REPORTED DURING THE THIRD QUARTER 2002

NO HOSPITAL OVEREXPOSURES WERE REPORTED DURING THIRD QUARTER
2002

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES REPORTED DURING THIRD QUARTER 2002

THERE WERE NO RADIOGRAPHY OVEREXPOSURES Reported DURING THE THIRD QUARTER 2002.

APPENDIX C

ENFORCEMENT ACTIONS FOR THE THIRD QUARTER 2002

Enforcement Conference: East Texas Medical Center Quitman, Quitman, Texas - Mammography

On July 25, 2002, an enforcement conference was held with representatives of East Texas Medical Center Quitman, holder of Certification No. M00402. The conference was held as a result of the number, type and severity of violations noted during an inspection conducted on February 21, 2002. The violations cited in the Notice of Violations issued on March 13, 2002 were reviewed and the responses to the violations were discussed.

The Agency reviewed the following recommendations with East Texas Medical Center Quitman.

1. Administrative penalties will not be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any severity level I, II or repeat violations are cited.
2. The Agency requests a written letter of commitment from the lead interpreting physician acknowledging that he has reviewed 25 TAC §289.230(k)(1)(A), and acknowledges the responsibilities of the Lead Interpreting Physician. The Radiation Safety Officer will provide the Agency with a signed statement of understanding indicating the Radiation

Safety Officer has reviewed 25 TAC §289.226(w)(2) and acknowledges and understands the responsibilities of the Radiation Safety Officer. This information shall be provided to the agency within 30 days from the date of the enforcement conference summary.

3. East Texas Medical Center Quitman will be placed on an increased inspection frequency and unannounced inspections will be conducted.
4. The Agency requests that East Texas Medical Center Quitman perform medical outcome audits for the twelve months prior to the date of the enforcement conference. The medical outcome audits will be reviewed at the next inspection.
5. East Texas Medical Center Quitman will submit a request to the Agency to change the Lead Interpreting Physician on the certification within 30 days of the date of the enforcement conference summary.
6. The Agency will revise one violation on the Notice of Violations issued March 13, 2002, reflecting the inspection conducted on February 21, 2002 to read: "The registrant failed to ensure that a technologist, who operated mammographic equipment, was a credentialed Medical Radiological Technologist, under Chapter 1096 of the Texas Civil Statutes, Article 451m, in violation of 25 TAC §289.230(f)(2)."
7. The Agency requests the Lead Interpreting Physician perform a monthly review of the quality control results for a period of twelve months beginning July 25, 2002. The results of each review will be verified at the next inspection.

The representatives from East Texas Medical Center Quitman agreed to the above recommendations and the Conference was concluded.

Enforcement Conference: Diagnostic Clinic of Longview, Longview, Texas - Mammography

On August 6, 2002, an enforcement conference was held with representatives of Diagnostic Clinic of Longview, holder of Certification No. M00349. The conference was held as a result of the number, type and severity of violations noted during an inspection conducted on May 14, 2002. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on May 14, 2002. The violations cited in the Notice of Violations issued on May 31, 2002 were reviewed and the

responses to the violations were discussed.

The Agency reviewed the following recommendations with Diagnostic Clinic of Longview:

1. The Lead Interpreting Physician will review the medical outcome audit for the period 1999 to 2000 with each Interpreting Physician and sign off that it was completed. This will be verified by the Agency at the next inspection.
2. The lead mammography technician and one assistant will attend a mammography quality control course and provide the Agency with copies of the certificates of completion. This recommendation shall be completed within 90 days from the date of the Enforcement Conference Summary.
3. The Agency requests Diagnostic Clinic of Longview remove or disable the safe-lights, which are not used in the mammography darkroom.
4. The Lead Interpreting Physician for Diagnostic Clinic of Longview shall review the quality control on a monthly basis for a period of one year. Following the one-year review, the quality control review may return to a quarterly basis.
5. Diagnostic Clinic of Longview shall write a procedure making it the responsibility of each mammography technician to confirm the required quality control has been completed and is in compliance before beginning mammography procedures.
6. The Lead Interpreting Physician will review the medical physicist's survey and sign off that it has been reviewed. This will be confirmed at the next inspection.
7. Diagnostic Clinic of Longview will be placed on an increased inspection frequency and unannounced inspections will be conducted.
8. Administrative penalties will not be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any severity level I, II or repeat violations are cited.
9. Prior to the commencement of any inspection the C.E.O. of the Hospital will be contacted by the Inspector.

The representatives from Diagnostic Clinic of Longview agreed to the above

recommendations and the Conference was concluded.

**Enforcement Conference: Graham General Hospital, Graham, Texas -
Mammography**

On August 15, 2002, an enforcement conference was held with representatives of Graham General Hospital, holder of Certification No. M00483. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on May 21, 2002. The violations cited in the Notice of Violations issued on June 10, 2002 were reviewed and the responses to the violations were discussed.

The Agency reviewed the following recommendations with Graham General Hospital:

1. Graham General Hospital will notify the Agency upon hiring of a new mammography technician.
2. Graham General Hospital will notify the Agency 3 days prior to start up of the mammography program.
4. Graham General Hospital will provide a statement to the Agency indicating the mammography technician will be supervised by the Director of Radiology. This shall be provided to the Agency within 30 days of the date of this summary.
5. The Lead Interpreting Physician of Graham General Hospital will review all quality assurance program test results on a monthly basis for the next year. The review period will begin September 1, 2002 and end August 31, 2003.
10. The Lead Interpreting Physician will provide a statement to the Agency indicating §289.230(k), (l) and (m) of the TAC was reviewed and the Lead Interpreting Physician understands the responsibilities as stated in this section. This shall be provided to the Agency within 30 days from the date of this summary.
11. Graham General Hospital will be placed on an increased inspection frequency and unannounced inspections will be conducted.
12. Administrative penalties will not be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any severity level I, II or repeat violations are cited.

The representatives from Graham General Hospital agreed to the above recommendations and the Conference was concluded.

Enforcement Conference: Golden Chiropractic Clinic, Houston, Texas – X-Ray

The Registrant did not attend the conference. Enforcement efforts are ongoing.

Enforcement Conference: David Wolf, D.P.M., Houston, Texas – X-Ray

On September 4, 2002, an enforcement conference was held with a representative of David S. Wolf, D.P.M., who is unregistered, however, an application for registration has been submitted and is pending. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on June 6, 2002. The violations cited in the Notice of Violations issued on June 17, 2002 were reviewed and the responses were discussed. Dr. Wolf was asked questions regarding his knowledge of a forged certificate of registration found during the inspection conducted at his Angleton office, on June 6, 2002. Dr. Wolf stated the registration had been forged by the previous Office Manager, and subsequently the Office Manager had been fired. Dr. Wolf indicated he had been registered previously and had terminated the previous registration in 1986.

The Agency reviewed the following recommendations with David S. Wolf, D.P.M.:

1. David S. Wolf, D.P.M. will provide a written statement to the Agency indicating he has reviewed, understands, and will abide by the Responsibilities of RSO as listed in §289.226(w)(2). Dr. Wolf will also review §289.203; §289.204, §289.205,
2. §289.226, §289.227, and §289.231 as will be listed on his registration, and provide a written statement to the Agency that he has reviewed, understands and will abide by the regulations.
3. Administrative penalties will be assessed to Dr. David S. Wolf, D.P.M. for operating without a valid registration and failure to comply with the Cease & Desist Order issued by this Agency on June 18, 2002.

13. The Agency requests Dr. Wolf move the area monitor for determining dose to public to an appropriate area and monitor this area for a period of six months.
14. Dr. Wolf will provide documentation from a licensed health physicist or service company indicating the X-Cel unit, Model No. P-75, Serial No. 3205 has had the collimation corrected in that the x-ray field size does not exceed the image receptor by more than 2% of the source to image receptor distance. This documentation will be provided to the Agency within 30 days from the date of the Enforcement Conference Summary.
6. Dr. Wolf will provide a copy of the re-certification for Alberta Robinson to the Agency within 30 days from the date of the Enforcement Conference Summary.
7. The inspection frequency for Dr. Wolf will be increased and unannounced inspection will be conducted at all three site locations.

The representative from David S. Wolf, D.P.M. agreed to the above recommendations and the Conference was concluded.

Enforcement Conference: Everest Exploration, Inc., Corpus Christi, Texas – Uranium

On September 6, 2002, an enforcement conference was held with Jim Clark of Everest Exploration, Inc., holder of License No. L03626. The conference was held as a result of the Agreed Order issued on February 25, 2002. The conferences with Everest are ongoing and are held approximately bi-monthly.

Enforcement Conference: McCamey Hospital, McCamey, Texas – Mammography

On September 10, 2002, an enforcement conference was held with a representative of McCamey Hospital, holder of Registration No. R01270. The conference was held as a result of the number, type and severity of violations noted during the inspection conducted on May 23, 2002. The violations cited in the Notice of Violations issued on June 18, 2002 were reviewed and the responses to the violations were discussed.

The Agency reviewed the following recommendations with McCamey Hospital:

1. McCamey Hospital will the radiation safety officer to an 8 hour Radiation Safety Officer training class within 90 days from the date of the Enforcement Conference Summary. A certification of completion will be provided to the Agency upon successful completion of the training course.
2. McCamey Hospital will develop procedures for testing the protective garments and performing light leak tests. These procedures will be added to McCamey Hospital's operating and safety procedures.
3. The Radiation Safety Officer will provide a written statement to the Agency stating §289.226(w)(2) has been reviewed, understood, and will be adhered to by the Radiation Safety Officer at McCamey Hospital. This shall be provided to the Agency within 90 days of the date of this summary.
4. McCamey Hospital will have an equipment performance evaluation preformed annually by a medical health physicist on the G.E. Unit, Model No. MST 625 II, Serial No. 40491WK5. The evaluation will contain the numeric values of the test and will be submitted to the Agency.
8. McCamey Hospital will submit to the Agency the numeric data taken by Radco Imaging for the entrance exposure measurements. Also include model name and type of equipment used to perform the entrance exposure measurements to the Agency within 30 days from the date of the Enforcement Conference Summary.
9. McCamey Hospital will be placed on an increased inspection frequency and unannounced inspections will be conducted.
10. Administrative penalties will not be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any severity level I, II or repeat violations are cited.

The representatives from McCamey Hospital agreed to the above recommendations and the Conference was concluded.